PRINTED: 09/21/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			nstruction 01	(X3) DATE : COMPL		
		155162	A. BUILD B. WING	ING		08/29/2	
	PROVIDER OR SUPPLIER			600 WA	DDRESS, CITY, STATE, ZIP CODE SHINGTON AVE H, IN46992	•	
					11, 1140392		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0000				İ			
	and State Licente conducted by the Department of accordance with Survey Date: Of Facility Number Provider Number AIM Number:  Surveyor: Amy Code Specialist At this Life Safe Autumn Ridge Centre was four compliance with Participation in Medicare/Medi Subpart 483.70 from Fire and the National Fire Association (NI Code (LSC), Chealth Care Octored (LSC), This three stored in the National Fire Association (NI Code (LSC), Chealth Care Octored (LSC), Chealth Care Octored (LSC).	ch 42 CFR 483.70(a).  28/29/11  r: 000081  er: 155162 100289570  r Kelley, Life Safety  tety Code survey, Rehabilitation and not in th Requirements for  caid, 42 CFR D(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing ccupancies and 410	K00	00	The creation and submission this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violative gulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of crediallegation and request a possurvey review on or after September 28, 2011.	not nis et on of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5REJ21

Facility ID:

000081

If continuation sheet

(X6) DATE

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155162	B. WING		08/29/2011
NAME OF F	PROVIDER OR SUPPLIER		ı	ET ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	I RIDGE REHABILI	TATION CENTRE	1	WASHINGTON AVE ASH, IN46992	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	construction ar	· · · · · · · · · · · · · · · · · · ·			Binz
		ne facility has a fire			
	alarm system with smoke				
	=	rridors, areas open			
	to the corridor	•			
	rooms 301 to 3	306 and 324 to 326.			
	The facility has	a capacity of 100			
	and had a cens	us of 47 at the time			
	of this survey.				
		Robert Booher, Life Safety			
	Code Specialist-Medical Surveyor on 09/07/11.				
	The facility was	found not in			
	compliance wit				
	aforementioned				
	-	s evidenced by the			
	following:				
K0029 SS=E	fire-rated doors) o extinguishing system and/or 19.3.5.4 pro	d construction (with ¾ hour ran approved automatic fire em in accordance with 8.4.1 otects hazardous areas.			
	When the approve				
		em option is used, the areas n other spaces by smoke			
	resisting partitions	and doors. Doors are			
		on-rated or field-applied hat do not exceed 48 inches			
		f the door are permitted.			
	19.3.2.1	•			
	Based on obser	vation and	K0029	K 029 To ensure a potentia	
	interview, the f			alleged hazardous area will equipped with automatic rele	
	ensure 1 of 1 r	oll down doors at		system to rolling fire door. T	he
		the kitchen wall, a		rolling fire door that serves a	
	hazardous area	a, would self close		opening through the dining r	OOM

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DINC	01	COMPL	ETED
		155162	A. BUII B. WIN			08/29/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ASHINGTON AVE		
ALITLIMAN	N RIDGE REHABILI	TATION CENTRE		1	6H, IN46992		
	NIDGE KENADIE	TATION CENTRE		WADAC			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	_	TAG			DATE
	upon activation	n of the fire alarm			and kitchen will be equipped		
	system. This o	deficient practice			release upon activation of th alarm. Overhead door	ie ilie	
	could affect all	residents in the			was notified and service call	was	
	main hall dinir	ia room.			scheduled All residents ha		
					the potential to be affected b		
	   Findings includ	do.			alleged deficient practice. The	ne	
	Findings includ	ie.			rolling fire door was equippe		
					release upon activation of th		
	Based on obse	rvation with the			alarm. All staff was inservice	-	
	Maintenance S	upervisor on			maintenance on the release rolling fire door upon activati		
	08/29/11 at 1	:35 p.m., the main			the fire alarm. No other area		
	dining room w	as open to the			was identified as having the		
	_	et the requirements			potential to affect residents		
		be allowed to be			staff. Rolling fire door is		
	•				equipped to release upon		
	_ ·	rridor. The wall			activation of the fire alarm.		
	around the din	ing room is			Environmental and Safety C	;QI	
	therefore, cons	sidered to be the			will be completed to ensure	of the	
	corridor wall.	There was a pass			proper function and release rolling fire door upon activati		
	through openi	ng in the corridor			the fire alarm. All staff inser		
		he dining room and			by maintenance on the relea		
		he opening was			rolling fire door upon activat	ion of	
		a rolling fire door			the fire alarm with pre/post t		
	_ ·				Environmental Safety CQI w		
	with a fusible I				completed by maintenance t		
	interview with	Maintenance			ensure the rolling fire door w release upon activation of of		
	Supervisor at t	he time of			fire alarm to ensure proper	i iiiC	
	observation, th	ne rolling fire door			functioning monthly. CQI wil	l be	
	does not close	upon activation of			reviewed after 6 months to		
	the fire alarm.	•			ensure threshold and will be		
					reviewed by CQI if not met.		
	3.1-19(b)				staff inserviced on rolling fir		
	3.1-19(D)				door being equipped to relea		
					upon activation of the fire all by maintenance with pre/pos		
	2. Based on o				test. The CQI team reviews		
	interview, the	facility failed to			audits monthly and action pl		
	ensure the cor	ridor door to 1 of 1			are developed as needed to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPL	ETED
		155162	B. WIN			08/29/2	011
			В. ТП		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L			SHINGTON AVE		
AUTUMN	N RIDGE REHABILI	TATION CENTRE			SH, IN46992		
					71, 1110002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	Central Supply	rooms measuring			ensure continual compliance. 09/28/2011 To		
	over 50 square	feet in size with			ensure a potentially hazard a	area	
	combustibles w	vas provided with a			will have an automatic self	"Ca	
	self closing device. This deficient				closure device installed on the	ne	
	_	ot in a resident care			door. For staff that could hav	e the	
	· ·	affect any number			potential to be affected by th		
		affect any number			alleged deficient practice, an		
	of staff.				automatic door closure was	-l	
					immediately installed on the No residents were identified		
	Findings includ	le:			be potentially affected. For	110	
					potentially affected staff, an		
	Based on obser	vation with the			automatic self closure device	was	
	Maintenance Su	upervisor on			installed on the door by		
	08/29/11 at 1:	•			maintenance. All staff inserv		
					by maintenance on automati		
		o the Central Supply			closure being applied to the		
		g nursing supplies			All potentially hazardous ar storage areas will have autor		
		boxes, measuring			self closure devices installed		
	over 50 square	feet in size, lacked			the doors by maintenance.	2 011	
	a self closing d	evice. Based on an			Environmental and Safety Co	QI	
	interview with t	the Maintenance			will be completed to ensure a		
	Supervisor at th	ne time of			hazardous area doors will ha		
	l -	confirmed the			functioning automatic self clo		
	·	room measured			devices on the doors. All sta		
					inserviced by maintenance o installation and functioning o		
	over fifty squar	e reet.			automatic self door closures		
	2.1.10/5)				potential hazardous areas.		
	3.1-19(b)				Environmental Safety CQI w	ill be	
					completed by maintenance to	o	
					ensure all potentially hazard		
					areas have automatic self clo		
					devices installed on the door	-	
					and ensure proper functionin weekly for 4 weeks then mor		
				for 3 months then quarterly	iu ii y		
				thereafter. CQI will be review	ved		
					after 6 months to ensure		
					threshold, and will be review	ed by	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155162	B. WIN			08/29/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			600 WA	ASHINGTON AVE		
AUTUMN	I RIDGE REHABILI	TATION CENTRE		WABAS	SH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG		بامما	DATE
K0038 SS=E	Exit access is arrareadily accessible with section 7.1. Based on obserinterview, the frequipped with a system, remain activation of the protective signal 19.2.1 requires compliance wit 7.2.1.6.2(d) receive building first signaling system automatically unthe direction of doors should naudible alarms the rest of the signal the system.	nged so that exits are at all times in accordance 19.2.1 exation and acility failed to irst floor exit doors a magnetic locking ed unlocked with e building fire aling system. LSC all exits be in h Chapter 7. LSC quires activation of e protection m shall nlock the doors in egress and the ot relock when the are silenced since system is still deficient practice y residents	KO	0038	CQI if not met. All staff inserving by maintenance on installation and functioning of automatic closure devices installed on a in potentially hazardous area with pre/post test. The CQI to reviews the audits monthly a action plans are developed a needed to ensure continual compliance. 08/30/2011  K 038 To ensure that first fixed exit doors remain unlocked wactivation of the building fire protective signaling system. It all residents having the potent to be affected, IEI was notified and system was repaired immediately. For all resident using the dining area having potential to be affected, IEI was notified and system was repaired immediately. All exit doors winspected for functioning and release with activation of the protective signal by maintenance functioning and release with activation of the fire protective signal. All staff inserviced by maintenance on the function release with activation of the protection signal with pre/postest. Environmental Safety and CQI will be completed by maintenance to ensure	on self doors as seam and as s	08/30/2011
	dining room ex	it.			functioning and release with		
					activation of the fire protectiv		
	Findings includ	e:			signal weekly for 4 weeks the	en	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155162 08/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH, IN46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE monthly for 3 months then quarterly thereafter. CQI will be Based on an observation with the reviewed after 6 months to Maintenance Supervisor on ensure threshold, and will be 08/29/11 at 2:30 p.m., the main reviewed by CQI if not met. All staff inserviced on functioning dining room exit door which was and release with the activation of equipped with a magnetic locking the fire protective signal by system failed to remain unlocked maintenance with pre/post test. CQI team reviews the audits when the fire alarm system was monthly and action plans are placed in silence mode. This was developed as needed to ensure acknowledged by the Maintenance continual compliance. Supervisor at the time of 08/30/2011 observation. 3.1-19(b)Exit and directional signs are displayed in K0047 accordance with section 7.10 with continuous SS=E illumination also served by the emergency lighting system. 19.2.10.1 K 047 To ensure that exit and K0047 09/07/2011 Based on observation, record directional signs are illuminated review and interview; the facility continuously. For all residents failed to ensure a continuously using the first floor area, having illuminated exit sign where the the potential to be affected by alleged practice, the illumination exit or way to reach the exit was of the sign was repaired not apparent was immediately immediately. For all potential visible for 1 of 4 ways to the exit. residents using the first floor, the exit/directional sign was repaired LSC 7.10.1.4 requires access to allowing illumination continuously. exits shall be marked by All exit/directional signs were approved, readily visible signs in checked for proper functioning by all cases where the exit or way to maintenance. No other findings. All exit signs will be checked for reach the exit is not apparent to functioning to ensure proper the occupants. This deficient functioning by maintenance. practice could affect any residents Environmental and Safety CQI will be completed to ensure all evacuating through the service

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155162		(X2) MULTIPLE CO A. BUILDING	onstruction 01	(X3) DATE	LETED		
		100102	B. WING		08/29/2	:U I I	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K0052 SS=F	corridor in the emergency.  Findings include Based on an obeomorphisms of Maintenance Survivers of the facility's Evacuation Plar the wall near the wall near the wall near the service hall emergency exit acknowledged Supervisor at the observation.  3.1–19(b)  A fire alarm system installed, tested, a accordance with N Code and NFPA 7 approved mainten	event of an  le:  eservation with the upervisor on 20 p.m., there was exit sign above the eading to the r. Based on review first floor map mounted on me main entrance, is used for an t. This was by the Maintenance me time of		exit/directional signs are functioning Maintenance Housekeeping inserviced on function of the exit/direction of the exit/directional signs was to the Preventative Maint Log. Environmental Saf will be completed by mai to ensure all exit/direction are continuously illuminal weekly for 4 weeks then for 4 weeks then monthly months then quarterly the CQI will be reviewed after months to ensure thresh will be reviewed by CQI to the most maintenance and Housekeeping inserviced on proper functioning of exit/directional signs. Preventative Maintenance revised to include checking proper functioning of the exit/directional signs. CQI reviews the audits month action plans are develop needed to ensure continuompliance. 09/07/20/	I by ED ectional added enance ety CQI ntenance nal signs ted twice weekly for 3 ereafter. r 6 old and eam if d I by ED  e Log ng for I team ly and ed as ual	DAIL	
	NFPA 70 and 72.  1. Based on obstinterview, the formula properly test and fire alarm systems.	9.6.1.4 oservation and	K0052	K 052 To ensure the fire system trouble signal is to destintive and descriptive annunciated. An annunciated panel for the fire alarm sywas installed. To ensure	o be ely ator /stem	09/28/2011	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	01	COMPL	ETED
		155162	B. WIN			08/29/20	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1	SHINGTON AVE		
AUTUM	N RIDGE REHABILI	TATION CENTRE			SH, IN46992		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Alarm Code. N	IFPA 72, 1-5.4.6			automatic dialer is in trouble		
	requires troub	le signals to be		mode that a trouble alarm would			
	located in an a	rea where it is likely			be heard in an occupied area Alarm was reinstalled For a		
		IFPA 72, 1-5.4.4			residents, staff and visitors th		
		arms, supervisory			could have been potentially		
	· ·	•			affected by the alleged defici		
	_	ouble signals to be			practice,an annunciator pane		
	distinctive and				the fire alarm system on 3rd		
	annunciated. <sup>-</sup>				is being installed and alarm veinstalled. All staff inservice		
	l ·	affect all residents,			maintenance on the annunci		
	staff and visito	rs.			panel and alarm in regards to		
					automatic dialers. Annuncia		
	Findings includ	de:			panel and alarms to signal		
					trouble is being installed on 3	3rd	
	Rased on an ob	oservation with the			floor and is distinctive and		
					descriptively annunciated. Preventative Maintenance lo	_	
	Maintenance S						
		:12 p.m., the main			updated to monitor functionir the annunciator panel and	·9 0·	
	· ·	el is located in the			automatic dialer component	to	
	electrical/mecl	nanical room			ensure they are distinctive a	nd	
	located in the	service hall which			descriptively annunciated.		
	was not contin	ually occupied			Environmental and Safety Co	ગ્રા	
	therefore a tro	uble signal could			will be completed to ensure functioning and annunciation	of	
		n this location at all			annunciator and alarms pane		
		lity does not have			staff inserviced by maintenar		
		panel for the fire			on annunciation and function	of	
					annunciator panel and alarm	s for	
	alarm system.				automatic dialer trouble	00'	
		the Maintenance			component. Environmental		
	Supervisor at t				will be completed by mainter to ensure functioning and	iaiio <del>c</del>	
	observation, th	ne service hall is not			annunciation of the annuncia	ıtor	
	occupied continuously.				panel and alarm for trouble of		
	. ,				automatic dialer component		
	3.1-19(b)				weekly for 4 weeks then mor		
	``'				thereafter. CQI will be review	/ed	
	2. Based on ol	oservation and			after 6 months to ensure threshold, and will be review	<sub>ed</sub>	
	2. Dased Oil Oi	Jaci vation and			unesnoid, and will be review	<del>c</del> u	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155162	A. BUILD	DING	01	08/29/2	
		100102	B. WING	CTDEET A	DDDEGG GITY GTATE ZID CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE SHINGTON AVE		
AUTUMN	N RIDGE REHABILI	TATION CENTRE			H, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	CQI team if not met. All staffe	-d	DATE
	interview, the f	=			inserviced by maintenance o		
		re alarm systems in			functioning and annunciation		
		h NFPA 72, the Iarm Code. NFPA			the annunciator panel and al indicating trouble of the autor		
	72, 1–5.4.6 rec				dialer component with pre/po		
		ocated in an area			test. CQI team reviews the a	udits	
	where it is likel				monthly and action plans are		
		1.4 requires fire			developed as needed to ensicontinual compliance.	uie	
		isory signals, and			September 28, 2011		
	•	to be distinctive					
	_	ly annunciated.					
	· ·	practice could affect					
	all occupants.	ractice could affect					
	an occupants.						
	Findings includ	le:					
	Based on an ob	servation with					
	Maintenance Su						
		21 p.m., when the					
		er component was					
		le from phone line					
	· ·	minutes, a local					
		vas initiated. The					
	dialer was loca	ted in the					
	   electrical/mech	nanical room					
	located in the s	service hall which					
	was not contini	ually occupied					
	therefore a tro	uble signal could					
	not be heard in	this location at all					
	time. The trou	ble signal was not					
	transmitted any	y other					
	continuously o	ccupied location.					
	Based on an int	terview with the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155162	B. WING			08/29/2	011
	PROVIDER OR SUPPLIER		•	600 WA	DDRESS, CITY, STATE, ZIP CODE SHINGTON AVE H, IN46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Τ	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	·	ation, he n alarm at the , but due to recent doesn't believe the					
K0056 SS=D	installed in accord Standard for the Ir Systems, to provice portions of the buit properly maintaine 25, Standard for the Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which ar the building fire ala Based on obser interview, the f ensure complete sprinkler system 1 of 1 water he of 1 Marketing accordance wit Standard for th Sprinkler System practice was no	rvation and facility failed to te coverage of the m was provided for tater rooms and 1 Director's closets in	K0	056	K 056 To ensure complete coverage of the sprinkler sys in the water heater room and Marketing Directors closet. F staff that could be potentially affected by the deficient prac sprinkler system was installed the closet of the marketing directors office by PIPE,INC. water heater room has sprinkled system present along back sof wall near piping. Water headoor is a fire rated door. Tag door was cleaned off to expo	in or tice, d in . The kler ide ater on	09/12/2011

<b>l</b> i '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155162	A. BUI	LDING	01	COMPLETED	
		155162	B. WIN			08/29/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	. DID OF DELLA DILLI	TATION OF NITE		1	ASHINGTON AVE		
AUTUMN	I RIDGE REHABILI	IATION CENTRE		WABAS	SH, IN46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	_
	of staff in the w	vater heater room			fire rating so that it was visible	II	
	or near the Mar	keting Director's			Facility audited and no other areas identified. Sprinkler he	II	
	office.				was installed in marketing	au	
					directors closet by PIPE,INC		
	Findings includ	e:			Water heater room has sprin		
					heads present along back sig	II	
	a Rased on oh	servation with the			wall near piping. Water heate room door had tag on door	er	
	Maintenance Su				cleaned off exposing fire ration	na so	
		05 p.m., the water			that it was visible. Facility	.5 -5	
	· ·	•			conducted an audit for areas	in	
		as not provided with			the building lacking sprinkler		
	•	d. The water heater			heads, and lacking fire rated		
	room was enclo	osed with block			doors. No other areas affects	<b>I</b>	
	walls but the do	oor was a nonrated			Housekeeping and maintena inserviced on	iice	
	hollow metal do	oor.			monitoring/presence of sprin	kler	
	b. Based on ob	servation with the			heads, and doors for fire ra	II	
	Maintenance Su	pervisor on			tags and avoidance obstructi	II	
		45 p.m., the closet			with paint etc Sprinkler hea		
		g Director's office			was installed by PIPE,INC.in marketing directors closet.		
	lacked a sprink	<del>-</del>			Environmental Safety CQI w	ill be	
	•	nowledged by the			completed by maintenance of		
	Maintenance Su	- ·			designee to ensure complete		
		•			coverage of sprinkler system		
	time of the obs	ervations.			areas and that fire rating tags doors will not be obstructed with the contraction of the		
					paint etc. weekly for 4 weeks		
	3.1-19(b)				monthly for 3 months then		
					quarterly thereafter. CQI will	be	
					reviewed after 6 months to		
					ensure threshold, and will be	<b>I</b>	
					reviewed by CQI team if not Housekeeping and maintena		
					inserviced on		
					monitoring/presence of sprin	kler	
					heads and avoiding obstructi		
					fire rating tags on fire doors		
					paint etc. with pre/post test CQI team reviews the audits		
					CQI learn reviews the audits		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155162	B. WIN			08/29/2	011
NAME OF F	DOWNER OF CLIPPLIED		!		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			600 WA	ASHINGTON AVE		
	I RIDGE REHABILI	TATION CENTRE	_	WABAS	SH, IN46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	<u> </u>	IAG	monthly and action plans are		DATE
					developed as needed to ensi continual compliance. September 12, 2011		
K0104 SS=F	Penetrations of sm protected in accord	noke barriers by ducts are dance with 8.3.6.					
ı	Based on obser	vation and	K(	104	K 104		09/28/2011
	Based on observation and interview, the facility fail to ensure 3 of 3 hall duct penetrations were provided with a smoke damper.  LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affects all residents since all residents rooms are located on the second and third floors.  Findings include:  Based on observations with the Maintenance Supervisor on				To ensure that hall duct penetral are provided with a smoke damper be installed.  All residents on floor 2 and floor will not have the potential to be affected by the alleged deficient practice due to smoke dampers being installed in the ventilation ducts that penetrate the smoke be wall on floor 2 and floor 3.  Ventilation ducts were inspected no other findings. Smoke damper will be installed in the ventilation ducts that penetrate the smoke be wall on floor 2 and floor 3.  Monitoring for maintenance of smoke dampers will be added the preventative maintenance log.	per. es will or 3  t n parrier d and ers on parrier the o the	
	installed in the				monthly for 6 months then CQI be reviewed to ensure threshold	, and	
	·	etrated the smoke			will be reviewed by CQI team is met. Monitoring for maintenance		
		the third floor and			has been added to Preventative	-	
	one ventilation				Maintenance Log.		
	=	smoke barrier wall			CQI team reviews the audits mo	-	
	on the second f				and action plans are developed aneeded to ensure continual	as	
	acknowledged	by the Maintenance			needed to ensure continual		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155162		(X2) MUI  A. BUILD  B. WING		01	(X3) DATE S COMPL 08/29/2	ETED	
	PROVIDER OR SUPPLIER			600 WA	DDRESS, CITY, STATE, ZIP CODE SHINGTON AVE H, IN46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	Supervisor at the observations.	ne time of			compliance. 09/28/11		
K0143 SS=E	wherein patients a treated by a separ 1-hour fire-resistiv (b) in an area that sprinklered, and his flooring; and (c) in an area post transferring is occur the immediate are accordance with N Compressed Gas. Based on obser interview, the fensure 2 of 2 a transferring of provided with compressed with a transferring of provided with a transferring or	any portion of a facility re housed, examined, or ation of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete ed with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 vation and acility failed to reas used for oxygen were continuous tilation. This ce could affect any third floor dining staff in the second ansferring room.	K01	43	K 143  To ensure that areas used for transferring of oxygen is provid with continuous mechanical ventilation. The continuous mechanical ventilations broken driver belt was repaired by maintenance.  Potential residents on floor 2 an floor 3 will not have the potent be affected by the alleged defici practice due to the continuous mechanical device being repaired. The continuous mechanical ventilation system was repaired maintenance. Monitoring the	d ial to ient ed.	08/30/2011

l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	A. BUILDING 01		COMPLETED			
155162			B. WING 08/29/2011					
NAME OF PROVIDER OR SUPPLIER				l	DDRESS, CITY, STATE, ZIP CODE			
AUTUMN RIDGE REHABILITATION CENTRE			600 WASHINGTON AVE WABASH, IN46992					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLEMENT)  TAG: DEFICIENCY)				
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE	
	08/29/11 at 1:	•			function of the continuous mechanical ventilation system will be			
	mechanical ven	tilation was not			added to the preventative	2		
	operating in the	e oxygen			maintenance log. Environmental Safety CQI will be completed to			
	transfilling/sto	rage room on the						
	third floor. Based on an interview with the Maintenance Supervisor at the time of observation, one mechanical vent motor controls the ventilation for the second and third floor oxygen transfilling rooms, therefore, the mechanical ventilation for the second floor oxygen transfilling room would not be in operation.				ensure functioning of the continuous			
					mechanical ventilation system.			
					Monitoring the function of the			
					continuous mechanical ventilati	on		
					system will be added to the wee	-		
					preventative maintenance log.			
					Environmental Safety CQI will	be		
					conducted monthly to ensure function of the continuous			
					mechanical ventilation system.	COI		
					will be reviewed after 6 months			
	not be in opera	cion.			ensure threshold, and will be			
	2.1.10/b)				reviewed by CQI team if not me			
	3.1-19(b)				The CQI team reviews the audit	s		
					monthly and action plans are			
					developed as needed to ensure continual compliance.			
					continual comphance.			
				08/30/11				
K0144		spected weekly and						
SS=C	exercised under load for 30 minutes per							
	month in accordance with NFPA 99.							
	Based on interv	view and record	l KO	144	K 144 To ensure a letter		09/12/2011	
		lity failed to ensure			confirming the reliability of		JJ, 12, 2011	
		source for 1 of 1			natural gas and low probabili			
					interruption of the natural gas			
	emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power				service is available at the fac A letter from NIPSCO will be	iiity.		
					available at the facility. All residents, staff and visitors will not have the potential to be affected by the alleged deficient practice due to the letter being of			
	Supply (EPS), 3-	-1.1 Energy Sources			current date and has appropri			
					115 - 15			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155162					(X3) DATE SURVEY COMPLETED			
		155162		LDING	01	08/29/2011		
100102			B. WIN		DDDEGG CITY GTATE ZID CODE	00/20/2011		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE				
AUTUMN RIDGE REHABILITATION CENTRE				WABASH, IN46992				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	documentation present. A	DATE		
	states the follo				current letter was obtained fi	rom		
		e permitted for use			NIPSCO. Letter contains supporting statements of			
	_	ncy power supply			of			
	(EPS):	oum products at			reliability and low probability interruption of service. Lette	• • • • • • • • • • • • • • • • • • •		
	a) Liquid petroi atmospheric pr	eum products at			be reviewed annually for cor supporting statements.			
	1							
	b) Liquefied petroleum gas (liquid or vapor withdrawal)				09/12/2011			
	<u> </u>							
	c) Natural or synthetic gas Exception: For Level 1 installations in locations where the							
	probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an							
	· ·	y source sufficient						
	to allow full ou							
		ver supply system						
		ivered for the class						
	specified shall	be required, with						
	the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:  1. A statement of reasonable							
	reliability of the natural gas							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155162		A. BUI	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 08/29/2011			ETED		
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE			B. WIN	B. WING OO/25/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  600 WASHINGTON AVE  WABASH, IN46992				
					511, 11 <b>4-</b> 0552		(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE  COI		
	delivery.							
	2. A brief desc	ription that						
	supports the st	atement regarding						
	the reliability.							
		that there is a low						
	· ·	nterruption of the						
	natural gas.							
	4. A brief desc	•						
	supports the statement regarding the low probability of interruption,							
	5. The signature of a technical							
	person from the natural gas							
	provider.							
	This deficient practice could affect all residents, staff and visitors.  Findings include:							
	Based on interv	riew at the time of						
	record review with the Maintenance Supervisor on 08/29/11 at 11:05 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) dated March 11, 2009 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an							
	emergency generator. The letter							

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155162			OMULTIPLE CONSTRUCTION (X3) DATE SURVING (X3) DA		ETED			
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE	
K0147 SS=D	lacked supporting statements of reliability of natural gas and low probability of interruption of the natural gas service. This was acknowledged by the Maintenance Supervisor during the time of record review.  3.1–19(b)  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  Based on observation and interview, the facility failed to ensure 1 of 1 power strips was not used as a substitute for fixed wiring to provide power for medical equipment. NFPA 70, National Electrical Code, 1999  Edition, Article 400–8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in resident room 309.		K0	147	K 147 To ensure that power strips are not used to provide power to medical equipment. Power strips were removed a electrical outlets installed. Facility was audited for use of power strips with medical equipment. No other findings Two residents will no longer legotentially affected by the produce to the installation of electroutlets. All staff inserviced the power strips are not to be used provide power to medical equipment. Electrical outlets were installed for use of medical equipment. All staff inservices maintenance that power striptical not be used for medical equipment. Environmental according to the stription of the stri	e and of s. be actice trical at no ed to s lical ed by ss	09/28/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5REJ21

Facility ID:

000081

If continuation sheet

Page 17 of 18

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155162		A. BUILDING	01	COMP 08/29/2	LETED			
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE  600 WASHINGTON AVE  WABASH, IN46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	were supplied were supplied were strip: a constitution maching treatment mach	upervisor on 2:20 p.m., the s of medical esident room 309 with electricity by concentrator, a le and a breathing nine. This was by the Maintenance		Safety CQI will be condumaintenance to ensure to power strips are not use provide power to medical equipment weekly for 4 then monthly for 3 month quarterly thereafter. CQ reviewed after 6 months ensure threshold, and wore reviewed by CQI team in All staff inserviced by maintenance on not using strips to provide power to equipment with pre/post CQI team reviews the automothly and action plans developed as needed to continual compliance.  09/28/2011	hat d to al weeks, ns then il will be to ill be f not met. ng power o medical test. The udits s are			